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Being a Catholic Physician at the Beginning of the Third Millennium

by

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Introduction

When we consider what it will be like being a Catholic physician in this, the third millennium, it seems at first blush that it will be difficult. It appears that there will be nothing but trouble. We are faced with a specter of medical practices that seem to be inspired by the Devil himself — abortion, physician assisted suicide, euthanasia, creation of embryos for experimentation, cloning of humans, harvesting of embryonic cells to create organ replacements and genetic engineering for enhancement purposes among others. These and other immoral practices, not as yet thought of, let alone perfected for practice, will be in the offing. In addition, there will be social moral issues, which will become medical moral issues for physicians. These concern the services that physicians render in the delivery systems now in place — the for-profit managed care health insurance companies, HMOs, and the like. The social, moral issues enumerated will demand in justice that we consider again some national health care reform program.

We now have a tiered health care system where some of us with connections and money can get the very best care in the world, but a very substantial part of our society is left to struggle to find it. 43 million of our most vulnerable citizens have no health insurance at all. Almost half of these are children. The for-profit systems are even now being revised and altered in ways to exclude medically costly vulnerable individuals —
children, the chronically ill, the elderly, and the dying — the purpose of
which is to provide health care services to only more healthy individuals.
Excluding the medically costly vulnerable groups from the system will reap
bigger profits for the entrepreneurs who control and manage the for-profit
systems and for their owners, the shareholders. More and more pernicious
and dubious legitimate business practices will be brought into the health
care arena, causing physicians to "game" the system. Using these dubious
business practices will create more moral problems for the physicians who,
in attempting to do the best for their patients, will begin to minimize,
exaggerate, or be untruthful in their reporting on their patient's medical
information to the insurance carriers.¹

There is real fear that the care system developed in America in the
second half of the twentieth century, based in the duality of the community
hospital and the well supported scientific medical research enterprise which
have brought to America the best, most complete, and highest standard of
care ever seen in the world, may well be eroded, if not completely
destroyed! It is feared that the sacred physician-patient relationship so
enshrined in the Hippocratic Oath will be for all intents and purposes non-
existent!²

Nursing care, which had reached the pinnacle of gentle, skillful, near
perfect practice in the 1950s (particularly in our Catholic community
hospitals under the tutelage of very skilled and very dedicated saint-like
nursing sisters) has already been dealt a deathblow by the leaders of the
national nursing organizations. The policies, which they have adopted and
put into operation, have stratified the nursing enterprise. The leaders, in
attempting to achieve educational and technical perfection, as well as
maximization of income, appear to have crucified "care" on the cross of
nursing professionalism! Now the individual closest to the patient in
giving personal care is the least educated and trained! The most highly
educated and highly trained individual in the nursing hierarchy is the most
removed from direct patient care! Such individuals have become
theoretical teachers and business managers no longer very expert in
personal care but long on talk of nursing theory and business practices.

Confronting Fears

Looking forward it does seem as if the third millennium is going to
be a pretty bleak time for physicians and other health care workers from
both the moral and professional standpoints. It would appear that we,
particularly as Catholic physicians, have much to fear.

But we, as Catholic physicians, with firm belief that Jesus is the
"Christ", the anointed one of God, and that the Church He established here
on earth during His earthly ministry will ever give us moral guidance as well as mental and physical succor, can always look to our Church’s authoritative Magisterium and our Church’s Tradition for inspiration, direction, encouragement and strength. Indeed, in our search we immediately come upon the words of our most modern and at the same time, most traditional of Popes, our current Holy Father, Pope John Paul II who, in anticipation of the third millennium, wrote at the beginning of his magnificent evangelistic tract *Crossing the Threshold of Hope*: “Be not afraid!”

These stirring words quoted by the Holy Father are but a repetition of the very words spoken by Christ on many occasions to men and women during His earthly ministry. God, speaking through the angel, said to Mary: “Be not afraid!” (Lk. 1:30) He said the same to Joseph when Joseph learned that his betrothed was with child. (Mt. 1:20) Jesus, the living Word of the Father, said the same to Peter, James, and John at the Transfiguration. (Mt. 17:8) Jesus said to Peter when he protested his sinfulness after the great catch of fish on Lake Genneserat: “Be not afraid! I will make you a catcher of men!” (Lk. 5:10) The risen Christ said the same to Mary Magdalene and the other Mary at the empty tomb: “Be not afraid!” (Mt. 28:10) Christ appeared to Peter and the other apostles after His Resurrection in the Upper Room and reproached them for their doubts and fears when He gave them the great commission to go out and evangelize the world. (Mk. 16:14) Yes, indeed! “Be not afraid!”

The Holy Father asks: “Of what should we be afraid?” He clarifies what this fear is. We are afraid of the truth about ourselves! And this truth about ourselves is that we are sinful. Thus, we are basically afraid of other humans because all are sinful. The systems that men create are always imperfect, the Holy Father says, and the more imperfect they are the more sure sinful man is of himself and the systems he creates! Thus we should take to our minds and hearts the admonition that John Paul II gave to the world at the very beginning of his ministry in the See of Peter, when on that early Fall evening in Rome, from the central loggia of the Mother Church of Christendom, he proclaimed to all so vigorously and with all of his apostolic authority as the Vicar of Christ on earth: “Be not Afraid! Open your heart to Christ.”

We need not fear, then, the third millennium if we take the Holy Father at his word. We need not cower and fear the evils, which we will face. Indeed, we need to confront them fearlessly, boldly, and courageously. We need to act forthrightly, each in our own way, and do whatever we can to eliminate these evils from our world. We can find our authentic course to sail into the new millennium undaunted by the
contemporary health care philosophical, social, clinical, and ethical trends if we are truly not afraid and if we truly open our hearts to Christ.

Now, certainly any one of the evils that I have listed above and many others not listed, which Catholic physicians will confront in the new millennium, could easily be the subject for a very lengthy, careful, detailed, and in-depth study. In such a study, we would spend much time in consideration of the particular evil from its historical development, and its causes, the reasons for its acceptance, the explication of its sinfulness, and the ways it may be opposed, diminished, or eliminated from the world.

However, in this paper I will address only one of these evils. That evil is the loss of a Catholic identity in health care, which is inevitable if we, as Catholic physicians, permit the current social, philosophical and ethical trends, along with market forces to invade health care and medical practice and destroy the Catholic community hospital. Erosion of this identity has already begun. I am happy to say that while the alarm has been raised, something is, indeed, being done to combat this evil. The Catholic Health Association under its new president, Rev. Michael D. Place, has developed plans to stop this erosion and combat the moral evils that such erosion will bring. We, as Catholic physicians, can also help greatly in stopping this erosion if we act and are “not afraid!”

The Historical Development of the Catholic Community Hospital in the USA

Community hospitals were almost non-existent in the United States until the middle of the 19th century. There were some, of course, which had been established in earlier times, such as the Pennsylvania Hospital in Philadelphia, founded by Benjamin Franklin in 1755, and the Massachusetts General Hospital established in 1821 in Boston. Some of the larger cities such as New York, Baltimore, Chicago, Cincinnati, New Orleans, Atlanta, and Savannah had public institutions (poor houses) for the care of the homeless, paupers, orphans, the elderly and the sick and dying. These, however, could not be considered as hospitals in the modern sense of the word. Nurses in such a hospital were often ill trained, coarse women with little compassion. Very often they were alcoholics.

Immigration to America increased in the early years of the 19th century as successive waves of families and individuals from Ireland, Scandinavia, the Rhineland and other German states arrived. Later, toward the middle of the century, waves of immigrants from Italy and the Slavic states of Eastern Europe arrived. These waves were almost always followed shortly afterwards from the same area in Europe by the immigration of evangelical ministers, priests, teachers, religious workers
as well as other talented individuals more educated and skillful that most of the earlier immigrants. Such individuals were highly motivated, deeply concerned for the welfare of their countrymen, and driven by a sense of duty and beneficence. They came to minister to the religious, educational, health, and social needs of their "cousins."

Many of these individuals were religious women such as Roman Catholic and Anglo-Catholic nuns and Lutheran deaconesses. These religious women realized that there were many important missions for them in the New World. The immigrants' children needed education, both secular and religious. Widows and orphans needed care. There was even a new mission in which the religious could take part. The native "heathen" population of the West needed to be evangelized! Thus, there were many opportunities for these religious women of the Old World to express their chrism in the new and different ways in the New World.

Groups of Catholic nuns came to America and spread all over the new country, particularly west of the Allegheny Mountains into then frontier areas. They set up their institutions — schools, orphanages, chapels, and missions — whatever seemed to be needed in the particular area to which they went. The Mercy Sisters were in Pittsburgh in 1835. Groups of the Sisters of Charity moved from New Orleans up along the Mississippi River and the Missouri River valley as the population began to expand into the territory purchased by Jefferson in 1803. The Daughters of St. Vincent de Paul and St. Louise de Marillac established foundations as needed. They were in St. Louis by 1840. St. Philippina Duchenne and her band of Madams of the Sacred Heart from France started their missionary activities for the Indians at St. Louis in 1850. The Franciscan Sisters, originally based in Chicago, established schools and other missions in Iowa, Nebraska, Minnesota, and the Dakotas from 1840 onwards. Mother Cabrini arrived in Chicago in early 1889. Between 1870-1900 Mother Joseph and her band of Providence Sisters went to the Pacific Northwest following the population expansion into Montana, Idaho, Oregon, and Washington State. In these locations they developed many foundations, especially for the Indians.

Often in an area where a natural disaster such as a flood or a tornado occurred, these women, though busy with their stated missions, frequently would be asked by the local community to provide for the nursing care of the victims. Even though the religious community's original mission was not nursing and though untrained formally for nursing, when asked, these women would step into the breech and provide the emergency care as best they could. This frequently led to a change from their original mission of teaching or evangelizing to the provision of health care. At times the people of a given settlement, for fear of contagion, even abandoned and

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banished from the community its sick and dying when a deadly epidemic struck. In such instances these women, eschewing danger to themselves, out of a sense of religious duty and love of God, would step into the void and organize needed care. They clearly understood that Catholic health care is an expression of Jesus’ healing ministry. As such, these good women understood the sacramental character of Catholic health care. This understanding has persisted to the present day, unchanged among those men and women involved in the Catholic health care enterprise.

Such tragedies of nature or of human misdeeds were often the genesis of a hospital in a given community. The famous St. Mary’s Hospital in Rochester, Minnesota, the hospital for the Mayo Clinic, came into being when Dr. Mayo, the town doctor of Rochester, asked the teaching Sisters of St. Francis of the Congregation of Our Lady of Lourdes to care for the victims of a tornado which struck the town in 1883. The Sisters of Charity in Springfield, Missouri started their hospital, St. Mary’s, as a temporary refuge and care project for the abandoned and dying citizens of the town when a cholera plague struck. Mother Joseph established some 20 hospitals in different communities in Oregon and Washington State when asked to do so by the communities in which she had other foundations.

**Current Statistics Concerning Community Hospitals in the USA**

What began in the middle of the 19th century for local community health care, often under religious auspices, has now developed into a vast system of hospitals, clinics, nursing homes, assisted care facilities, hospices, etc., all serving the American people from coast to coast. Presently there are about 5,000 hospitals in the USA. Of these about 4,000 are community hospitals of 300 beds or less. About 1,000 are medical centers, including academic medical centers associated with a medical school. Hospitals of this type usually have about 500 beds. Some have 1,000 beds or even more, i.e., Bellevue Hospital in New York City, associated with the Medical School of New York University, which has 1,300.

Of the 5,000 hospitals in the United States, 10% are Catholic, i.e., sponsored by dioceses, Catholic congregations of women and men religious, or by Catholic lay people who have the imprimatur of the local ordinary. The very heart of the system developed the culture of the Catholic hospital. This heart has always been the religious sister. In 1922 there were between 15,000 and 20,000 religious sisters working in the Catholic hospitals of the United States. Charles Moulinier wrote in 1921: “There is a spirit, a soul, an atmosphere and ideal of service in the sisters’
hospitals which they create and maintain and give their lives’ best efforts to foster.”9 The culture of the Catholic hospital has been well articulated by Father Richard McCormick. He writes: “Catholic hospitals exist to enact in the health care setting what God did in Jesus. The Catholic hospital exists, therefore, to be Jesus’ love for the other in the health care setting. It has the daily vocation of telling every patient — especially the poor- and every employee how great they are, because Jesus told us how great we are and in the process empowers us.”10

These hospitals call themselves “Catholic” because of their history, their relation to the local ordinary, and the fact that they all operate in accordance with the Ethical and Religious Directives for Catholic Health Care Facilities issued by the National Conference of Catholic Bishops.11 In some communities the Catholic hospital is the only health care institution in the town. Often the only hospital in the region is a Catholic one. This is particularly true in the mountain states and the far west — the result of those pioneers’, Mother Joseph and her Providence Sisters’, works of mission and charity done in the 19th century.

The actual number of hospitals identifying themselves as Catholic in the USA is 569. These hospitals combined have a total of 132,259 beds at the time of this writing. In 1998 they provided 30,286,062 in-patient days of care. 1,551,433 in-patient surgeries and 2,423,451 ambulatory surgeries were done in these hospitals in 1998. They employed 592,020 full time equivalent personnel. Their total expenses in 1998 were $46,582,628,665. Their payoff in 1998 was $20,247,753,014.

The business dimensions of Catholic health care in the United States as an aggregate is quite strong. Our Catholic health ministry is spread over the whole USA. In 19 states the Catholic health care ministry has a 20% share of the health care business. Total revenues for the enterprise in the USA are over $47 billion. These figures compare quite favorably with one of the largest of the for-profit hospital corporations, Columbia-HCA. In 1997, Columbia-HCA owned over 300 hospitals across the USA and had a total of 60,000 beds. In only three states did it have a 20% share of the health care business. Its revenues in 1997 were $14.6 billion. Its physical assets totaled $16 billion.12

Genesis of the Problems Encountered by Hospitals in the USA at the Threshold of the Third Millennium

Hospital construction supported by generous federal funding sources (the Hill-Burton program) in the second half of the twentieth century provided hospital beds in most every community in the United States. At this same time the third party payers for hospital care (Blue Cross, private May, 2002
health insurance, and the government programs — Medicare and Medicaid) were more than generous in paying for hospitalized patients. Although hospital care is labor intensive, hospital wages were kept low purposely during the 1950s and 60s, which made the per diem cost of a hospital bed reasonable. Third party payers paid per diem charges or costs, whichever was less. Hospitals negotiated with third party payers for reimbursable costs. The federal-state Medicaid program enacted by the Congress and initiated in 1965 paid for many patients for whom formerly a hospital would have given free care. Hospitals in the third quarter of the twentieth century were very well off, indeed, from a financial standpoint.

After the Vietnam War in the late 1960s and early 1970s, inflation began to occur. Hospital employees began to unionize and fight for living wages. Per diem costs for hospitalization began to rise and health care insurance premiums began to increase. The third party payers began to scrutinize hospitalizations more closely. They set up instruments to monitor the appropriateness of hospitalizations, length of stay, and levels of care. Preadmission approval for hospitalization began to be required from the third party payers. Covered services were reduced. All of these efforts did not stem the rising tide of per diem costs. In 1950 the per diem cost of a bed at the Johns Hopkins Hospital in Baltimore was $29. In 1990 it was over $400!

Health care was in crisis! Serious problems arose for hospitals, physicians, and other health care institutions and workers. The Clinton administration, which assumed office in 1991, sought but failed to bring about a reform which was designed to reduce expenditures for health care and include more individuals in health insurance programs. With this failure, a transforming change occurred in the financing of health care in this country. Market forces took over and the private health insurance sector developed for-profit programs of managed care. Physicians could no longer alone make decisions concerning health care services. Hospitals were no longer independent in their activities. Patients, physicians, and hospitals were now guided by the rules and regulations put forth by the managed care organizations. It became readily apparent under these new circumstances that most communities were far over-bedded, from the standpoint of hospital care. Managed care rigidly insisted that a needed level of care be given only in the appropriate institution designed for that level. Thus, hospitals were turned into intensive care units and downsized. Same day surgery was inaugurated. Rehabilitation care was transferred to nursing homes. Long term nursing home care was transferred to a facility designed for assisted living. The managed care organizations put into place very rigid oversight procedures for all medical treatments, hospitalizations, and surgeries. They set up rigid protocols that patients, physicians, and
hospitals had to follow. The managed care programs negotiated discounted payment programs for the care of their insured with hospitals, physicians, and other health care providers. Managed care systems allowed no inclusions for charity care, teaching of residents, or research activities to be included in their negotiated payment schedules with either community hospitals or academic medical centers.

The result of all of this change has been most disastrous for hospitals, both community hospitals and the academic medical centers. The number of hospitalized patients fell dramatically. The length of stay shortened greatly. Income to hospitals decreased precipitously. Hospitals reacted in different ways to these disastrous changes.

Some hospitals have closed. Others have sought to find additional enterprises to stay in business such as setting up surgicenters, birthing centers, or comprehensive health care systems. Other hospitals merged together. For Catholic hospitals, both community and academic health centers, additional problems have occurred. The most important of these revolves about Catholic identity.

Consideration of Catholic Identity

In a superb communication considering Catholic identity in health care, Father Bryan Hehir first describes three models of care in the development of the Catholic health enterprise. The first he calls the immigrant model, the second the Vatican II model, and the third the Catalyst of Social Change model. I have described his immigrant model in the section above, which is entitled "Historical Development of Catholic Hospitals in the USA." The second model, Hehir says, is a product of ecclesial initiative which arose from the Church’s councilor vision to take the essential tasks rooted in the Gospel — teaching, healing, and social service — and to think about them in terms of a Church at the service of society as a whole. Hehir says that the Vatican II model still drives our conception of ministry and identity, as it ought to. But he goes on to say that the catalyst of the 1990s is rooted: "not so much in ecclesial initiative as in the imperative and the challenges posed by social forces."

With the failure of the Clinton administration in its effort for health care reform, Hehir says that American society must confront the very fundamental and basic question not just about health care but about social policy. This effort obviously entails the most fundamental moral questions as well as secular and technical questions. The first is what are the content, scope, and extent of the state’s moral responsibility? The second is what is society’s responsibility for the poor and the vulnerable? The third is what is the moral role of the market? Hehir recalls that the first pope to highlight
the value of the market — John Paul II — immediately followed his commendation with a discussion of the moral limits of the market. If health care is to be driven only by the market, we clearly will not reach even a minimal moral standard.

Catholic health care is a ministry, but one within a context. Currently, the market shapes the context. The Catholic health care ministry is both an actor in the system and an advocate for the most vulnerable among us. The role of being actor and being advocate simultaneously is filled with tensions. Actors must survive, but actors who fulfill a ministry cannot survive at any cost. To reclaim our identity, Hehir says, involves reflective evolution in our understanding of ourselves, faced with the demands of health care in the late twentieth century America. Defining one’s identity as a ministry roots it in both ecclesial and moral soil. He points out that the final document of Vatican II, “The Pastoral Constitution of the Church in the World” (1965) discusses the Church’s identity and ministry. The Church is in the world, not the Church and the world, never the Church apart from the world, nor simply over against the world.

A second issue to be considered in the problem of identity in Catholic health care concerns the role of the religious congregations and their members in the operations of the hospitals, which they founded. There has been a great reduction in the number of professed religious in the past 40 years. Thus there are few religious men and women now left to staff their congregations’ hospitals. Remembering what Moulinier wrote in 1921, some would say that we have lost our heart. But others correctly realize that the “heart” of the Catholic hospital has changed. Maintaining the mission of the founders is one of the challenges for the new heart of Catholic health care today.

Possible Solutions to the Problems Catholic Hospitals Face

The Church now locates itself precisely in the context from which the challenges to our ministry arise. It lives in the midst of the fabric and fiber of life where real decisions are being made. Hehir points out clearly in his paper that our presence in the world is radically human. Our service is to the human person and to human dignity. Vatican II insisted that the Church stand as the transcendent sign of the dignity of each human person. Pope John Paul II in his encyclical Redemptor Hominis (1979) wrote: “the person is the way for the ministry of the Church.” To be in the world, we must be in dialogue with the world. The Council said this is how the Church shows its love for the world and this is by being willing to be in dialogue about all the issues that touch the human person. The critical question these considerations raise now is what should our posture be as
institutions strategically located in society. The answer to this is very clear and very plain — our institutions must be truly Catholic through and through.

Pope John Paul II's encyclical of 1995, *Evangelium Vitae* (The Gospel of Life), moves us from focusing on identity as our place in society to how we engage a set of specific issues. It moves us from ecclesiology to moral argument. The encyclical is best understood as a passionate call for defense of a specific moral vision. The pope makes his moral arguments in cosmic categories arguing that there is a competition between a "culture of life and a culture of death."

The pope divides these threats we face into three categories: ancient, modern, and postmodern. The ancient are hunger, poverty, famine, and genocide, all arising from man's inhumanity to man. The modern threats are more complicated. They arise not from the worst within us but often from the best. The enormously significant human insights, inventions, and creativity have paradoxically often produced choices we seem unable to make or to control. These modern threats to life arise out of the ambiguity that is in the best of us. Our scientific insights outpace our moral capacity to make judgments about preserving human dignity. For example, we have extended the life span of everyone and we now find ourselves wondering whether we contribute to the dignity of the patient or erode it!

Health care is at the heart of the ambiguity of the modern threats to life. Once again, just as the Catholic style is never to leave the world to avoid its risks, the Catholic moral style is never to deny what was done or wish that it had not been done. When human intelligence reaches toward the truth, it is always a grace, but we are left with the task of bringing our moral vision to match our intellectual insight. The pope in his encyclical *The Gospel of Life* expresses the fear that we do not know how to think well about protecting human dignity and promoting human rights in a world framed by the ancient and modern threats to life. Combining the "Pastoral Constitution" and the principal arguments of *The Gospel of Life* Hehir writes that the key themes emerge, which provide the framework for what we are and what we stand for today. These themes are a commitment to sacredness, an understanding of stewardship, and a deep conviction about the social fabric of life.

A commitment to sacredness entails not only a philosophical statement that life is sacred, but that the development of a personal attitude, which is evident in the way we approach every human person who comes to be healed and cured. This also involves the development of a social attitude that radiates from institutions as well as the development of a professional sense of awe when we stand in the face of the mystery of every human person, well or ill.
A sense of stewardship involves maintaining a conviction that life is a gift and not simply a product. Such a conviction means that we stand in the face of a mystery that is larger than we are. Life comes to us from God and will be taken back from us by Him. We are entrusted with life: we do not own it. Such a posture provides direction for methods of health care and sets definite limits that should not be transgressed. This principle of stewardship in Catholic thought must also guide our approach to economics, as well as to bioethics.

The social fabric of life involves a conviction that we are bound together in a single destiny and that we are social by nature, not by choice. From this conviction flows the understanding that being human means accepting accountability, personally, professionally, and institutionally, for the lives of others.

Catholic health identity requires an institutional strategy. Thus we have to make choices and apply tactics in the face of the challenges. The first step in a strategy is to be aware of the value of institutional presence. Institutions cannot do everything, but they will fundamentally shape the quality and character of life. We must develop an integrated witness — both a horizontal and a vertical integration in the Church. Strategic vision needs to be developed across the range of Catholic institutions in the United States. We can never do this adequately by thinking about institutions separately. Vertical integration means that institutions like hospitals and health care facilities can be related in the future to parishes, for example, in whole new ways. This is a leading edge of where we need to go in changing forms of health care.

Some Catholic community hospitals have attempted to overcome their financial difficulties and survive by affiliating with other Catholic health care institutions. This is an example of horizontal integration. This horizontal integration has produced some excellent Catholic health care systems, which spread across several states or indeed encompass the whole United States. The Daughters of Charity Health Care System, headquartered in St. Louis, is one such example. The Providence Health Care System in the Pacific Northwest is another excellent one. These unions have brought financial strength, economy of operation, and stability for those community hospitals which have entered into such a system.

Other Catholic community hospitals, especially when relatively isolated geographically, have sought for the same reason — financial stability and survival — to merge with a non-Catholic hospital in the vicinity. These mergers may have brought financial stability to the operations and a false sense of survival but at what price? Really at the
loss of Catholic identity! Such mergers are fraught with moral dangers of immense proportions.\textsuperscript{14}

In such mergers, the Catholic partner has always attempted to remove itself a great distance from those practices which non-Catholics find morally licit, but which Catholic faithful, true to the traditions of the Church and its magisterial teaching, find evil and illicit. Specifically the Catholic partner seeks to remove itself from responsibility for those practices, which the Church knows are evil, but which are sanctioned in its partner’s institution. Such practices are artificial contraception, contraceptive sterilization by tubal ligation or vasectomy, abortion, physician assisted suicide (where legally permitted), in vitro fertilization, artificial insemination by donor, embryo third party uterine implantation and the like. The fourth section of the Bishops’ \textit{Ethical and Religious Directives for Catholic Health Institutions} points out clearly, and in great detail, the theological aspects concerning cooperation with an institution which sanctions immoral practices. It is forbidden!

When one institution merges finances and operations with another, they are no longer two distinct and separate corporations. They are one. Responsibility, from then on, rests upon the single corporation, which has subsumed the Catholic corporation as a co-equal owner. In such an arrangement there is no question but that Catholic identity is gone even if the “former” Catholic hospital remains a geographically separate structure in which trustees, administration, physicians, and staff all agree that no practices prohibited by the Bishops’ \textit{Ethical and Religious Directives} will ever be performed at that site and/or in that particular structure! In such an arrangement Catholic identity is gone! It would have been better to close the Catholic hospital and use the proceeds from its sale to establish some other needed health care facility in the region fitting into the charism of the founders. For example, a nursing home for chronically ill patients, or an assisted living facility for the elderly could be operated by the congregation as a new activity consistent with their mission of health care. There is no disgrace in admitting that one has fulfilled one’s mission as originally defined. Once done, then one can go on to do other things yet consonant with the mission.

Germain Grisez, a well respected moral theologian, has considered the moral implications of many different types of mergers. These range from simple contractual arrangements, forming integrated delivery networks with broad affiliations, co-sponsored health maintenance organizations, and/or arrangements for a purchased portion of the practices of a group of physicians and/or other providers. In his book \textit{The Way of the Lord Jesus} referred to above, Grisez clearly shows how all these arrangements cannot really ever be remote mediate material cooperation, a
situation that the *Directives* permit. Often when a Catholic hospital does enter into such arrangements even with the most distant type of remote mediate cooperation, scandal occurs. Such scandal is reported in a lengthy article in the *Wall Street Journal*. This article described the merger of the Niagara Falls Memorial Hospital in Buffalo with the Daughters of Charity’s St. Mary’s Hospital in the same city. This merger had the imprimatur of Bishop Henry Mansell of the Buffalo diocese. Yet the report indicated that some of the arrangements were merely subterfuges to get around “The Directives.” The faithful were shocked by this revelation.

The heart of the Catholic hospital is still as large as it ever was and the Catholic hospital still has its mission, but the dedicated individuals who must operate the hospital and carry out its mission are now different! The individuals are no longer dedicated sisters, for very few of them are left. The Bon Secours Health Care System based in Marriotsville, MD owns and operates 29 hospitals throughout the country. There are 28 professed religious women in the Congregation of the Sisters of Bon Secours as of this date. They joke that each sister has her own hospital! But the religious leadership of the System, foreseeing this state of affairs a decade ago, very carefully planned for this needed change in “its heart.” It took Paul’s instructions seriously. “There is a variety of gifts but always the same Spirit; there are all sorts of services to be done, but always the same Lord; working in all sorts of different ways in different people, it is the same God who is working in all of them. The particular way in which the Spirit is given to each person is for a good purpose.” *(1 CO 12:4-7)* It has recruited, indoctrinated, educated, and trained intelligent and faithful Catholic lay persons in its mission and vision. It has commissioned these individuals to carry on the operations of its system and its hospitals in the tradition of the founders. This action has met with great success. Their system survives and thrives in the present health care environment and clearly remains “Catholic” to its core.

The Daughters of Charity have set up a national health care system, which operates their hospitals throughout the country. They have 80 hospitals, nursing homes, and clinics across the country. Last year their net revenue was more than $20 billion. They have a reserve fund of over $2 billion. Again with very careful planning initiated over a decade ago the Daughters prepared dedicated lay people to understand their mission and vision, and they educated them to operate their hospitals in accordance with these. The Sisters who were in their hospitals continued to work and provide a symbolic presence and a witness to the charism of the Congregation.

A good example of this farsighted action is Providence Hospital, a community hospital in the Daughters’ system in northeast Washington,
D.C. It is thriving! Its president, Sister Carol Keehan, D.C. and one other nun are the only religious on the staff. There are several retired sisters who do volunteer as “Patient Visitors” and help the chaplains as ministers of communion. But Sister Carol has successfully educated her lay staff to operate the hospital in the spirit and charism of the founders. She exudes the spirit of the founders. She knows every employee. Her own enthusiasm is infectious and she imbues this enthusiasm and spirit into every aspect of Providence Hospital’s operations.

Conclusion

Indeed, when we consider the Catholic community hospitals’ future, i.e., what it will be like in the third millennium in our country, some Catholic physicians may be pessimistic, cynical, and despairing. But we should rally around our beloved Pope John Paul II and heed his words: “Be not afraid!” Catholic community hospitals must survive but with a distinctive posture and presence in our society. They must remain true to our Catholic moral principles. It is clear, as Father Hehir says, that the logic of health care reform, whether it comes by systematic planning or purely by market forces, includes the reduction of the number of Catholic health care institutions. The maintenance of our institutional presence is the challenge for us, particularly where viability must be preserved within the ambit of ecclesial and moral integrity.

But the real problem we Catholic physicians face as we enter the third millennium transcends health care and is purely moral in nature. Daniel Callahan, director of the Hastings Institute, argues this in his book, What Kind of Life. What is plaguing our health care system, he says, is an illness that inheres in the heart of the nation. It is a problem of vision — of how we see, whom we value, and what we believe. Many of the nation’s most cherished values and beliefs are hostile to a coherent, just and economically feasible health care system. It is precisely because most efforts at changing the system have been attempted within the framework of those dominant cultural values that they have not succeeded. To the degree that the assumptions underlying our health care system and proposals for reform are not uncovered, critically examined, and altered, reform will continue to fail. The late beloved Pope John XXIII in Pacem in Terris lists medical care as a means “necessary and suitable for the proper development of life.” (#11). The U.S. Bishops in their 1981 “Pastoral Letter on Health and Health Care” also expressed the conviction that health care is a right. Health care reform may well be far more difficult than anticipated, for it is generally easier to change structures than to transform

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a culture’s ethos! The revisioning of health care is at the same time a revisioning of our fundamental moral commitments.

As Catholic physicians, we can do much right and contribute greatly in meeting this great challenge if we act morally, do right, and are “not afraid.”

References


